STATE OF DELAWARE GROUP HEALTH INSURANCE PROGRAM
Verification Form for
Double State Share (DSS) Coverage

Completion of this form is required to ensure compliance with DSS plan eligibility.

IMPORTANT – FOLLOW THE STEPS BELOW:

Step 1 – Complete this form to verify your DSS eligibility. One form must be completed for each contract of health plan coverage (if you and your spouse are enrolled in separate health plans, each of you will need to complete this form).

Step 2 - Return the completed form no later than Friday, March 30th

* **Obtain the electronic form at www.ben.omb.delaware.gov/dss, complete and print for signature or manually complete and return form.**
  - Scan and e-mail to benefits@state.de.us;
  - Fax to (302) 739-8339; or
  - Mail to Statewide Benefits Office, 97 Commerce Way, Suite 201, Dover, DE 19904

Employee/Pensioner Information

Employee/Pensioner Name: _____

Select one of the following:

- ○ State of DE Employee
  - Employing Agency/School District/Charter School: _____
  - Employee ID: _____
- ○ Delaware Transit Corporation
- ○ DE Solid Waste Authority
- ○ University of DE
- ○ DE State Housing Authority
- ○ State of DE Pensioner on Long-Term Disability
- ○ State of DE Pensioner
  - Pensioner ID: _____

Current Coverage Choice: (*Select one below)*

	YOUR CURRENT DSS HEALTH PLAN			
	Highmark Delaware First State Basic PPO Plan	Aetna CDH Gold Plan	Aetna HMO Plan	Highmark Delaware Comprehensive PPO Plan
Employee	○	○	○	○
Employee & Spouse	○	○	○	○
Employee & Child(ren)	○	○	○	○
Family	○	○	○	○

Spousal Information

Name of Spouse: _____
Date of Marriage (mm/dd/yyyy): _____
Select from the following for spouse's ***CURRENT*** status:

- ○ State of DE Employee
  - Employing Agency/School District/Charter School: _____
  - Employee ID: _____
- ○ Delaware Transit Corporation Employee
- ○ DE Solid Waste Authority Employee
- ○ University of DE Employee
- ○ DE State Housing Authority Employee
- ○ Spouse is ***CURRENTLY*** working for an employer other than the State of DE or one of the groups indicated above.
  - Current Employer: _____
  - Employee ID (if applicable): _____
  - Is spouse in a full time benefit eligible position? Yes ○ No ○

  Please indicate below, which State of DE or group listed above that your spouse last worked for as a full-time benefit-eligible employee (if applicable):
  - Employing Agency/School District/Charter School: _____
  - Employee ID (if applicable): _____
- ○ State of DE Pensioner on Long-Term Disability
  - Pensioner ID: _____ (enter Spouse SSN if Pensioner ID is not known)
- ○ State of DE Pensioner
  - Pensioner ID: _____ (enter Spouse SSN if Pensioner ID is not known)
  - Is spouse currently receiving a State of DE pension check? Yes ○ No ○
- ○ Spouse is deceased

  Are you receiving a survivor's pension? Yes ○ No ○

CERTIFICATION (everyone must sign and date)

By my signature below, I hereby certify the statements made on this form are true. I understand that I may be required to provide copies of my marriage certificate and/or birth certificates for dependents enrolled in my DSS health plan coverage as requested by my HR/Benefits Office.

EMPLOYEE/PENSIONER SIGNATURE: _____

(Please print this form, sign and return to your HR/Benefits Office)

DATE (mm/dd/yyyy): _____